Jam-packed with both quantitative and qualitative information. So first, I would like to welcome each and all of you to this wonderful opportunity to listen to Dr. Leith Leon and Leti Torres about their very important mixed methods research work focusing on the Cervical Cancer Prevention Program in Mexico. Before I do that, I do want to mention that this is the inaugural seminar for our newly-minted CMIPS Maternal-Child Health Promotion Program, and we very intentionally highlight the word promotion because we think there is already a lot of knowledge about risk factors for many, many major serious conditions affecting women and young children, and that it is really time to focus more on solutions and on how to co-design effective programs, how to evaluate them, how to scale up these programs. And I am very pleased that today’s seminar is co-sponsored by the Yale Scholars in Implementation Science Career Development Program from the Yale School of Medicine,
the Global Health Concentration from the Yale School of Public Health and the Global Oncology Program at the Yale Cancer Center.

And all of us who represent those programs as well are very grateful to CMIPS for the opportunity.

Just a little advertisement, if I may, the Maternal-Child Health Promotion Program has really been launched with a lot of enthusiasm.

And under the leadership of Dr. Amber Hromi-Fiedler,

we now have a formally approved Maternal-Child Health Promotion track for the MPH students in our school.

And we also are working very diligently under the leadership of Amber on the development of Maternal-Child Health Promotion pathways for PhD students across departments in the school.

We are also very engaged in advancing Maternal-Child Health Promotion research within Yale,

across institutions, both in the US and globally.

And I feel especially proud about today’s webinar because the reason we found out about the wonderful work,

Donna already knew about it,
but that I found out about the wonderful work from Leith and Leti was because they both gave an amazing lecture as part of the summer implementation science course that we did in partnership with the National Institute of Public Health in Mexico, which is the institution where both of them work.

So Leith Leon-Maldonado is a doctor in public health, who is working as a researcher in the Department of Cardiovascular Diseases, Diabetes Mellitus, and Cancer at the Center for Population Health Research or CISP, and is also a faculty member of the School of Public Health at the National Institute of Public Health in Mexico. And that is the School of Public Health in Mexico and is accredited by CISP.

She worked on zoonosis programs at the Michoacan Health Services, which is a beautiful state in Mexico, and has helped coordinate the FRIDA and FASTER-Tlalpan studies on cervical cancer screening. Her principal areas of interest are alternatives for the prevention.
and control of cervical cancer and HPV infections and associated cancers.

Leti Torres-Ibarra is a doctor in science, who is also a researcher and faculty member in the same department at INSP as Leith is. Her translational research has consistently aimed at reducing HPV cancer burden. She has been working to carry out a process of technological assimilation for cervical cancer prevention and control within the Mexican healthcare system, and has contributed to the design and execution of large studies aimed at evaluating cervical cancer screenings.

The results of her quantitative evaluation of alternative HPV vaccination schedules for girls has become a cornerstone of the World Health Organization updated recommendations for HPV immunization.

And I also know that Leti happened to be, I think, a predoc/postdoc scholar at Harvard under the mentorship of Dr. Donna Spiegelman.

So please join me in welcoming Leith and Leticia by clapping with your symbols if you can. And I want to give them the floor.
so that they can start illuminating us with their talks.

Welcome. (speaks in foreign language)

Thank you very much.

Thank you for the invitation, thanks.

Thank you, Rafael, for this wonderful presentation.

And I really would like to thank all of you for having us.

And I really very excited to share with you the experience and challenge in implementing the Cervical Cancer Prevention Program in Mexico.

So let me share my screen.

Can you see my screen now?

Yes. Yeah, we can see it.

Okay.

So...

Okay.

So in this talk, we are going to talk about cervical cancer.

Why?

Because this is a public health program that caused premature death, and this is a preventable disease that cause hundreds of thousands of women deaths every year.

And cervical cancer now,

it’s an example of a preventable disease.

As we can see later,

mortality due to this disease.

is a manifestation of health inequity.
Unfortunately, where women lives, her socioeconomic ethnocultural or immigration status mean the difference between life and death from this common cancer, which already... This cancer, worldwide, in the 2020, caused more than 600,000 incident cases and more than 300,000 deaths. As I mentioned, as you can see in these two maps, the top map represent the incident cases and the bottom one represent the mortality rates. And you can see that more than 85% of the cases are diagnosis in less developed countries, where cervical cancer rocking second only after breast cancer. In regions with the scarce resource, fragile or fragmented health services, this cancer contributes to the cycle of poverty. This, despite we have proven cost effective interventions available for this cancer, as you can see in these maps, we can observe substantial variations between regional and geographic countries. For example, in this map, and that represent the... The mortality rates were white. We can see that the more intense orange are the countries with the highest mortality rates.
What happened in Mexico about the incidents?

This cancer is the second most commonly diagnosed cancer among women. And according to IARC in 2020, 9,000 new cases of cervical cancer occur in Mexico. Here is important. I would like to mention that, for many years, we didn’t have a population-based cancer register. But the good news is that in the last five years, the field record has been created in a city, in desert of Mexico, in the peninsula of Mexico. And we are very excited because probably at short term, we can have data too. a more accurate data about this disease. And cervical cancer is a second leading cause of death, also in Mexico among women, among Mexican women. Annually, more than 4,000 women death by this disease. A similar disparity exists within our country. And in this map, you can see the 32 states of Mexico and the states located at the south of Mexico are the states with the highest social deprivation and also are the states with the higher mortality rates than the rest.
You can see in this map, the mortality rates is twice the... The mortality rates...
Sorry, the mortality rates in this area is twice the mortality rate of Mexico City.
And this is an example that this cancer... is influenced by determinants of access to health.
And this situation, these early situations happen now in a era where we have options available for primary and secondary preventions, which offer an excellent opportunity to intervene more effectively against this cancer.
So now, we can see that women shouldn’t have to die from this disease. Actually, in 2018, the WHO Director Dr. Tedros, made a global call for action towards elimination of cervical cancer because, as we know, we now have the tools to eliminate the disease through the vaccination and through the screening. In this slide, I would like to show how the prevention program in Mexico is made up. We have the body strategies, primary prevention through vaccination and secondary prevention through screening.
The vaccination is focused as a public health program. It's free, and it's focused in girls 9 to 11 years old. And then secondary prevention through this training depends of the age, the women below 35 years old are screening with Pap smear, and women from 35 to 64 years old are screening using HPV as primary screening test. Just a summary. As you probably know, HPV vaccines have an excellent safety efficacy against the HPV infection and against cervical cancer and another HPV-related disease. There are three licensed HPV vaccines, quadrivalent, bivalent, and nonavalent. In this year, we celebrate the 15 years since the first HPV vaccine was FDA register. The first two vaccines available that were quadrivalent, bivalent vaccines include protections against HPV 16 and 18, that are the main HPV types that contributes to 70% of cervical cancer cases. The inclusion of the other seven high-risk HPV types that are the HPV 31, 33, 45, 52, and 58.
will increase the protection to almost 90% of the infection.

So these are great news.

By December in 2019, 100 countries had introduced HPV vaccine in their national immunization programs for girls, mainly in high-income countries.

At present, 70% of current cervical cancer cases occur in countries that have not yet introduced HPV vaccine.

And that is why continuous screening is still required, but the scaling up and sustaining programs in routine health service in that countries is challenging.

I would like to know that Mexico along with Panama were the fierce middle income countries that introduce HPV vaccination in 2008.

Mexico has a universal HPV immunization program since 2012.

This photo shows our former Mexican president, our former Ministry of Health in a public event, launched the immunization program. The HPV vaccine is to all girls or to those girls of 11 years old since 2012.
We have a school-based vaccination program, and we use a two-dose schedule. The first dose is administered at month zero, and then at six months later.

Here, I will like to mention that Mexico was a pioneer to implement alternative vaccination skills, again, HPV since 2009.

Probably your question, why reduced the number of doses? The standard dose schedule was three doses at month zero, two, and six. But since the beginning, Mexico proposed an alternative vaccination schedule against HPV because of cost saving and programmatic advantage that may facilitate high coverage. So at the beginning, Mexico proposed an alternative vaccination schedule of month zero, six, and at that month, and five years later.

But after provide evidence that a booster five years later is no longer need, we have now an alternative dose schedule at month zero and month six. Why this? Because this is called saving. Reducing one dose have an impact and an easier administration.
We have one visit less to the primary schools. This strategy allows us to increase the coverage, saving dozens of doses of vaccine to reach more girls. According to many studies, it has been proven that this is a cost-effective strategy if a vaccine coverage reaches more than 70%. We can increase adoption of the immunization program in populations with limited healthcare access. Another reason to change this dose regimen is that if we adopt this dose schedule, we can reduce the loss to follow up in this population. And as I mentioned, I would like to share these results of a non-randomized clinical trial that our group conducted since 2009. This trial was established in Mexico. We enrolled more than 1,000 healthy girls, almost 500 women to test if alternative dose schedules were not inferior to the standard dose schedule. Our results show that after five years, the immunogenicity of the bivalent HPV vaccine in Mexican women is safe and produced antibodies in immune response with antibody levels that remain stable over five years after primary immunizations. In this green line, you can see the GMTs,
the geometric mean titers of the HPV vaccine with a standard dose schedule. And in this wine bar, we can see the immunogenicity levels of the two dose schedule. And we can see that this immune response is above the natural infection. And we found that this antibody response was not inferior to the response observed in girls of the same age. These results, along with another results of other studies, contribute to the recommendation of the WHO about the HPV vaccination that now says that two-dose schedule in years aged 9 to 14 years is support. In Mexico, I can say that the acceptability of all vaccines, it’s very, very high. These are the results of a study conduct in Mexico City where in this study, the investigators asked to mothers of girls about the acceptability of HPV vaccine, and there is a high acceptability of almost 90%. The reasons for not acceptance among these mothers were not knowing enough about HPV. because (indistinct) is not a risk for HPV infection.
or because they think that the HP vaccine is a new vaccine or they are unaware of the side effects.

In adults, our group also have conducted an study to evaluate acceptability among adults. We can observe that the acceptability of the HPV vaccine, it’s also very high.

Now, we have a new challenge in HPV vaccination in Mexico. First, we have a shortage of vaccine since 2019. The bivalent vaccine company exits the market. So we have now a monopoly of HPV vaccine. In 2016, GSK made a decision to stop supplying Cervarix.

Now, we have to... Probably, we’ll have to buy the other vaccines but are more expensive. And the situation worsened with the SARS-CoV-2 pandemic. As you know, in Mexico, the schools were closed until two months ago. And so we need catch-up programs to reach those girls.

And briefly, I would like to share the experience about cervical cancer screening. And just to remember, the goal of the cervical cancer screening is reduce the burden of cervical cancer by the early detection of cervical precancers.
that can be timely treated to prevent progression to invasive cancer. Unfortunately, the impact of the program has been insufficient in Mexico, despite the resource allocated since 1974. Most of the cervical cancer cases in Mexico are detected at advanced stage of the disease, explaining the high mortality. In this graph, you can see the bars are the deaths. This gray line is the standardized mortality rate. Unfortunately, the call reducing the mortality rate to less than 11 in 2012 was not met. The reasons why these efforts are harboring insufficient, why that we have a healthcare system that is fragmented, is enabled to provide infrastructure resource and quality control required in each of the stage. From the screening to appropriate management of diagnosed cases. For many years, we have used the publish screening test that has a low sensitivity to detect cervical precancer at the beginning of the '90s.
And evaluation of the quality of cervical cytology specimens in Mexico report that more than 60% of the samples were inadequate. In addition, some of the cervical cytology screening centers report more than 50% of false negative results. We have an opportunistic program with low coverage, and also we have a lack of tracking system for abnormal cervical cancer screening follow-up. That’s why the WHO now recommends that high risk HPV will be the primary screening test for cervical cancer in countries and regions that don’t have an effective Pap program. Mexico introduced the HPV test as the primary screening test in the National Cervical Cancer Screening Program in 2009. Our research group has a lot of experience evaluate the usefulness of the HPV DNA in more than 250,000 of Mexican women through four demonstrative projects. The results of these large projects show that HPV is more sensitive than Pap smear, that a single HPV test is more sensitive that even two Pap tests in a one-year period, that HPV test by vaginal self-collection
404 00:28:23.070 --> 00:28:27.180 detects more than four times more invasive tumors
405 00:28:27.180 --> 00:28:29.673 when compared to cervical cytology.
406 00:28:30.990 --> 00:28:33.750 but also we learn that if we refer
407 00:28:33.750 --> 00:28:36.330 all HPV positive women colposcopy,
408 00:28:36.330 --> 00:28:39.180 we can cause a large burden to the system,
409 00:28:39.180 --> 00:28:43.293 so triage test is required.
410 00:28:44.700 --> 00:28:49.530 This is our HPV-based Cervical Cancer Screening Program
411 00:28:49.530 --> 00:28:52.740 that was launched in 2008.
412 00:28:52.740 --> 00:28:57.740 First, women should attend the primary health center
413 00:29:01.878 --> 00:29:05.343 where the cervical sample collection is made up.
414 00:29:07.080 --> 00:29:10.503 The high risk HPV test is offered.
415 00:29:12.600 --> 00:29:15.843 When the program was launched,
416 00:29:17.460 --> 00:29:22.460 the implementation of this program launch new challenge
417 00:29:23.850 --> 00:29:26.010 because the modification of the program
418 00:29:26.010 --> 00:29:31.010 have an extra medical visit to obtain a new cervical sample
419 00:29:31.710 --> 00:29:33.423 for cytology triage.
420 00:29:35.160 --> 00:29:37.803 So in this program,
421 00:29:39.060 --> 00:29:44.060 the women have to return to receive the result of HPV.
422 00:29:46.710 --> 00:29:50.793 And if they have an HPV positive result,
423 00:29:52.051 --> 00:29:56.270 a second cervical sample should be collected.
424 00:30:00.810 --> 00:30:05.810 Then depends on the results of the triage with cytology,
425 00:30:07.680 --> 00:30:12.250 the women have to return for a third visit
426 00:30:13.255 --> 00:30:15.210 to diagnosis confirmation.
427 00:30:15.210 --> 00:30:18.180 Unfortunately, there was an increase
428 00:30:18.180 --> 00:30:22.080 in the loss of follow-up among high risk HPV positive women
as a consequence of these multiple visits to acquire an adequate sample for cytology and because of the lack of tracking systems. And these problems add to the limited clinical accuracy of cytology which offer, as you remember, only a sensitivity of 40% to the test cervical intraepithelial neoplasia. So now we have modified this program, one visit was removed. Now, the women go to the primary health center for the cervical sampling. And then she has to come back only for the results of the HPV, and the cytology has triage. Unfortunately, after these modifications, we remains some challenges. We now have a very low follow-up to colposcopy of Pap positive women. We only have 43% of women with abnormal Pap smears that are successfully follow up to diagnosis confirmation. The women who are attending in colposcopy have a low proportion of biopsy collect to confirm that the diagnosis. So this... In this slide, I only want to say that HPV test is effective for cervical cancer detection, but it’s not enough.
In Mexico, according to the National Health and Nutrition Survey in 2012, the self-report Pap smear or HPV in the last 12 months, it’s only 50%. So we have many barriers to meet the screening coverage of more than 70%.

We have barriers like access in marginalized or remote places. We still having some logistical issues of transportation, these blood options, vaginal or urine subsample, can be excellent strategies to reach more women and to overcome the challenge of coverage. These blood options, vaginal or urine subsample, can be excellent strategies to reach more women and to overcome the challenge of coverage.
And in summary, I think that these are our challenge in the Mexican Cervical Cancer Screening Program. We have to increase the coverage. We have to improve the participation, and probably we have to incorporate these alternatives to pelvic examination. We have to improve the efficiency of screening to detect women in the highest cancer risk using a more efficient triage strategies. We have to install a cancer information system. That this cancer information system can facilitate the follow-up to another stage like the follow up to colposcopy. But also we have to talk about this implementation of some strategies like the Pap smear as primary screening test in some institutions in Mexico. But we have to talk about what will be the role of the cytotechnologist that work in Mexico. So as you know, we have now effective interventions, but we have an effective cervical cancer prevention program in Mexico. And finally, I would like to thank to our two senior investigators. The evidence in Mexico has been possible
thanks to the leadership of Dr. Eduardo Lazcano
and Dr. Jorge Salmeron, who are our mentors. And thank you so much.

So I think the speakers have requested for all questions to be answered until both presentations are completed, if that is okay with you, so that we can Leith now go on to make her presentation.

Can you see it? Not yet. Can you see it now? Yes.

Again, hello, everyone. My name is Leith Leon-Maldonado. I work for the National Institute of Public Health in Mexico, INSP, as a researcher and faculty member.

Thank you, Donna and Dr. Rafael Perez-Escamilla for the invitation.

Amber, thank you. It is an honor.

As Dr. Leti Torres comment, in this second part, I will address implementation of cervical cancer prevention strategies based in two studies conducted in Mexico. The experiences and lessons that we have learned.

That Dr. Escamilla said,
I will answer the question at the end of my presentation.

In the first part, Leti told you why cervical cancer continues to be a public health in Mexico. This has led to search for alternatives to face the border of cervical cancer in our country. In a scenario where around 4,000 women die per year, Mexico has the advantage of having introduced early prevention strategies such as vaccination against HPV and HPV test as a strategy to face the disease. That is decision making has narrowed the gap between evidence and action. However, to have implemented novel strategies wasn’t enough.

We faced challenges. Mainly because the program continues having difficulties in increasing coverage and achieving a decrease in mortality. We can ask ourselves why. What’s happening in the program? Why don’t women get screened? And even when we have a more effective screening tool, that is the HPV test, why don’t return to the follow-up? Did we have problems.
during the implementation of the HPV test, or could it be the strategies? But Leti said the evidence suggests that they are affected. Could it be the implementation of the strategies? Surely the answer is not unique, and it’s not simple in a complex program. Let’s talk about what we have learned. Within the line of research on HPV and cancer in INSP, studies have been carried out that show the difficulties on the Cervical Cancer Prevention Program. Today, I tell you about two studies. One conducted in Michoacan State and another in Mexico City carried out in 2011. Complex scenarios were vulnerable and disadvantaged women reside and have greater risk of cervical cancer. The analysis presented is part of a large study that we included interviews with women.
in different types of screening.

The findings of the group of women who have received their HPV results are presented today.

What is counseling?

We can understand counseling as a directive, dynamic, flexible process in an environment of trust and empathy.

It is a process of communication, advice, listening and solving to facilitate decision making.

In the context of the Cervical Cancer Prevention Program, it is intended that women are informed about HPV screening test, clear their doubts about different topics. They express their concerns about HPV infection, the vaccine, cervical cancer, and make assertive decision for prevention by using counsel.

The study approach was qualitative. It was approved by IRB, an informed consent was obtained in all the cases.

Women who recently received their HPV results were interviewed in two settings, urban area and an Indigenous communities with different level of marginalization.

During the interviews,
beliefs, perceptions and experiences about HPV,
cervical cancer and screening were explored.
The participants were between 33 and 66 years old.
46% of the Chilchota women spoke Purepecha and 75 were beneficiaries of Oportunidades Program.
The education level was six years or less in 75% and 73 didn’t have paid jobs.
Oportunidades was a program to support families living in poverty to improve the capacities for nutrition, health, and education, providing financial resources and services. In this study, briefly, I present some of the resource on information and counseling needs. The findings are topics of HPV, including doubts about the transmission of the virus, the severity of the infection. For example, a woman from Morelia said that she would have like to ask if HPV is transmitted by having several partners. And a woman from Chilchota had doubts about what HPV is and how it is transmitted. Another topic of interest was about the screening test, the usefulness of the test, the procedures, the meaning of the results, HPV results,
HPV test results and public results. Why the test results are different? A woman from Chilchota felt sad when she doubt about the having HPV result and another words confused about the meaning of the words positive and negative. Another issue was the stigma about HPV, including doubts about infidelity. The recommendation of these study are to straighten information about counseling, about HPV and cervical cancer to mitigate sadness and anxiety and stigma. The Pap was already part of the program. In the output after implementation, unnecessary emotional impact was identified, such as stigma, fear, and uncertainty. Doubts about testing, including the Pap smear.
Despite being used in Mexico for over 50 years.

What happened inside of the black box?

We can’t explain the input and the output, but we can explain the results.

What procedures were implemented and how were implemented in the practice.

Were the procedures different in urban areas than in a foreign or indigenous context?

We need to block the black box, open it, and study how behavior, culture, knowledge influence.

We don’t know.

By observing the results from the implementation,

we can ask ourselves.

What is happening to the intervention?

What was the problem?

The effectiveness of the intervention of each implementation.

Next, I’m going to share our experiences and what we learned from the FASTER-Tlalpan study.

FASTER is an strategy aimed that proposed to combine the HPV vaccine and the screening based in the HPV test in adult women between 25 and 45 years old.

FASTER was conducted in real conditions.

Vaccination and screening were introduced.

combined as Cervical Cancer Prevention Program.

FASTER is a randomized clinical trial,
was implemented in eight healthcare centers in Mexico City.

It was approved by IRB.

Once FASTER study was carried out in healthcare centers,
we aim to evaluate the results of the implementation
of a strategy like FASTER from the accessibility
and feasibility components.
The question is if a strategy like this were introduced
in Cervical Cancer Prevention Program,
would it be acceptable?
Would it be feasible?
The innovation was the vaccine since the HPV test
was already an standard procedure in Mexico.
Therefore, acceptability vaccine
among the participant women was evaluated
using our open questionnaire.
We also evaluate the acceptability.
We use an interview guide with doctors and nurses
based on the study objective, the literature,
and the theoretical framework.
The feasibility was evaluated using a checklist
to identify the minimum infrastructure
needed for vaccination and screening.
There are the tools we use to evaluate these components.
And number one, we used to ask about the reason
for accepting or rejecting the vaccine.
Number two, we used to evaluate acceptability from the perspective of the health professionals. And number three, we use to evaluate the feasibility.

We can identify the minimum infrastructure necessary for vaccine and screening. Here are some of the results about the reasons to accept the vaccine. 93% of women accept HPV vaccine. Some of the reason for accepting were prevention and healthcare motivated by sexual behavior, medical history, fear, and benefits of the vaccine. The susceptibility of HPV vaccine among adult women allow us to understand their responses, their response to a vaccination if a strategy like this were implemented in health services. However, some comments suggest that it is necessary to refer the counseling and training or help professionals who provide counseling. While the rejection of the vaccine was less than 10%, the reason for rejection could represent the barriers to the implementation of the vaccine at the population level. For example, the perception about the vaccine not being safe,
lack of confidence and information about the benefits,

health education, counseling and dissemination of the information.

Good health increase awareness and promote positive attitudes toward vaccination.
The findings from health professionals suggest a positive attitude towards vaccination
and the combined strategy.

Among the vaccination benefits are decreased incidents
and cervical cancer mortality,
prevention over treatment.

To implement the strategy at population level, approximately 25% of the participants
believe they were no obstacles at all.
There is the perception that women would accept the HPV vaccine
and the great challenge to decision making at institutional level.
They identify deficiencies in infrastructure, supplies,
medical personnel, as well as health information.
The barriers are machismo, myths, and mistrust.
Regarding the feasibility in terms of minimum infrastructure
necessary to implement the vaccine on the screening,
it was observed that eight healthcare centers
had a fridge to store the vaccines and 75% had a generator
and 88 had at least one portable cooler.

As for the screening, no healthcare center had a specific space.

50% performed cervical examination in shared doctor’s offices.

And the other 50% didn’t have a space for the screening.

63% had an examination table and a lamp and not had a private space for delivering results and counseling.

It is important to remember that the screening had been part of the prevention program established in Mexico since the ’70s, and that infrastructure should be in place in healthcare centers.

The findings suggest that it is feasible to implement a combined strategy.

However, if it’s advisable to address weaknesses of the program by improving screening infrastructure, having the supplies and improving attention to users, informing them of the procedures and benefits of these tools, screening and vaccination.

Even when the vaccines is acceptable, we must not forget the reason for rejection.

In order to avoid implementation barriers, implementing the combined strategy not only means having the vaccine at the same time as a screening, but also strengthened the program operation.
Finally, returning to the idea of the black box, the input of the Cervical Cancer Prevention Program is implementation of the HPV vaccine. The HPV test was already part of the program. The results suggest that it could be feasible to implement the vaccine and screening and the vaccines have high acceptability among women and health professionals. But what happened inside of the black box again?

What did we do to achieve high vaccination acceptability and how we did it? We need to block the black box, open it, and study how to achieve acceptability and how we can reproduce the intervention at population level. How can we replicate it and be sustainable? That is the challenge.

Thank you very much for your attention. It’s a pleasure to share our experience with you.

Thank you very much, Leith and Leti. Very, very complimentary talks. I know we’re right on time now. We are scheduled to continue meeting with Leith and Leticia for the next hour together with the CMIPS team,
818 00:54:52.020 --> 00:54:54.490 but I’m sure if any of you want to stay on
819 00:54:55.620 --> 00:54:58.500 you could stay to ask questions.
820 00:54:58.500 --> 00:55:01.110 Are we staying in this Zoom, William, or-
821 00:55:01.110 --> 00:55:03.150 <v ->No, I think there’s a different one,
822 00:55:03.150 --> 00:55:04.710 Rafael,</v>
823 00:55:04.710 --> 00:55:07.260 but maybe we could take, you know,
824 00:55:07.260 --> 00:55:09.780 just a few minutes to take a question or two.
825 00:55:09.780 --> 00:55:12.900 <v ->Yeah, Vinita had her hand raised</v>
826 00:55:12.900 --> 00:55:15.506 right after Leti finished her talk.
827 00:55:15.506 --> 00:55:15.506 <v ->Yeah. </v>
828 00:55:16.339 --> 00:55:17.400 <v Vinita>Yeah, hi.</v>
829 00:55:17.400 --> 00:55:19.920 My name is Vinita Parkash, I’m a pathologist.
830 00:55:19.920 --> 00:55:22.710 And so I guess my question to you was,
831 00:55:22.710 --> 00:55:26.247 why does your cytology sort of...
832 00:55:27.840 --> 00:55:30.120 I think you said that the performance
833 00:55:30.120 --> 00:55:33.090 had a very high false negative rate.
834 00:55:33.090 --> 00:55:35.640 What type of Pap smear are you doing?
835 00:55:35.640 --> 00:55:38.010 Is this liquid-based cytology?
836 00:55:38.010 --> 00:55:40.470 And the second question is,
837 00:55:40.470 --> 00:55:44.610 what is the training for cytotechs in Mexico?
838 00:55:44.610 --> 00:55:46.890 I’ve run programs in India,
839 00:55:46.890 --> 00:55:51.250 so we’ve been able to bring up the performance
840 00:55:52.735 --> 00:55:55.519 of our cytotechs, and we’ve actually come up
841 00:55:55.519 --> 00:55:56.352 with a very different program
842 00:55:56.352 --> 00:55:58.593 from the one that is used in the US.
843 00:56:03.540 --> 00:56:04.373 <v ->Thank you.</v>
844 00:56:05.520 --> 00:56:10.520 For many years, we have used the standard
845 00:56:12.300 --> 00:56:16.080 Pap smear.
846 00:56:16.080 --> 00:56:20.220 because there is a lack of training
about how to collect the samples among the nurses.

And also because there are a lot of mucus and blood in the cervical samples and the training...

I think that the main issue is the lack of quality control among our cytotechnicians and our cytopathologists because, for many years, we have not implemented quality control mechanisms to ensure that these professionals have the ability to read and to interpret these slides.

And recently, we have incorporated a liquid-based cytology and this is a great opportunity to do the HPV test and the liquid-based cytology using the same sample. I think this can improve our screening program.

But yes, you’re right. We have a large percentage of false negative samples.

Sorry, thank you.</v> Okay, are there any other questions?</v>

Okay, if not, I know Leith that you will be meeting with Beth as well after the meeting with CMIPS.

And I will be there at that meeting, Beth, so that you know, okay?

So thank you all very much,
and I guess we all at CMIPS need to move to another Zoom link to continue our conversations with Leti and Leith. Thank you very much. Thank you. Bye, everybody. (overlapping chatter)